PAIN-MANAGEMENT CLINIC REGISTRATION

FLORIDA STATUTES
Sections 458.3265 and 459.0137, Florida Statutes

BOARD RULES
Chapter 64B8-9, Florida Administrative Code
Chapter 64B15-14, Florida Administrative Code

DEPARTMENT RULES
Chapter 64B-4, Florida Administrative Code
Chapter 64B-7, Florida Administrative Code

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HOW TO COMPLETE A PAIN-MANAGEMENT CLINIC REGISTRATION FORM

The following instructions apply to the registration form.

THE REGISTRATION MUST BE TYPED OR PRINTED IN BLUE OR BLACK INK AND A SEPARATE APPLICATION MUST BE COMPLETED FOR EACH PAIN-MANAGEMENT CLINIC.

GENERAL INFORMATION

Sections 458.3265 and 459.0137, Florida Statutes, provide that any publicly or privately owned facility that advertises in any medium for any type of pain-management services or where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisopropol for the treatment of chronic nonmalignant pain must register with the Department of Health (Department). Your business is exempt from registration if:

- Licensed as a facility under Chapter 395, Florida Statutes;
- Majority of physicians who provide services in the clinic primarily provide surgical services;
- Owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;
- Affiliated with an accredited medical school at which training is provided for medical students, residents or fellows;
- Does not prescribe controlled substances for the treatment of pain;
- Owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);
- Wholly owned and operated by one or more board-certified anesthesiologists, physiatrists, or neurologists; or
- Wholly owned and operated by one or more board-certified medical specialists who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who are also board-certified in pain medicine by a board approved by the American Board of Medical Specialties or the American Osteopathic Association and perform interventional pain procedures of the type routinely billed using surgical codes.

EACH LOCATION MUST BE REGISTERED SEPARATELY REGARDLESS OF WHETHER THE PAIN-MANAGEMENT CLINIC IS OPERATED UNDER THE SAME BUSINESS NAME OR MANAGEMENT AS ANOTHER PAIN-MANAGEMENT CLINIC.

Pain-management clinics must designate a physician responsible for complying with all requirements related to registration and operation of the pain-management clinic. The designated physician must be a medical doctor licensed under Chapter 458, F.S. or an osteopathic physician licensed under Chapter 459, F.S., who holds a full, active and unencumbered license. Each pain-management clinic must notify the Department of any change in designated physician within 10 days. Failure to do so may result in a summary suspension of the pain-management clinic's registration certificate as described in s. 456.073(8), F.S. or s. 120.60(6), F.S.

Each physician practicing in a pain-management clinic shall advise the Board of Medicine, in writing, within 10 calendar days after beginning or ending his or her practice at a pain-management clinic.

THE DESIGNATED PHYSICIAN MUST PRACTICE IN THE REGISTERED PAIN-MANAGEMENT CLINIC FOR WHICH HE/SHE IS RESPONSIBLE.

The pain-management clinic must be inspected annually by the Department unless it is accredited by a nationally recognized accrediting agency approved by the Board of Medicine or Osteopathic Medicine. If the pain-management clinic is accredited by one of these agencies, please provide the Department with documentation showing that the accreditation is current.

SECTION I: OFFICE INFORMATION

1a. Indicate if the pain-management clinic is wholly owned by a physician licensed under Chapter 458 or Chapter 459, F.S. or a group of physicians, each of which is licensed under Chapter 458 or 459, F.S.; or is a health care clinic licensed under Part X of Chapter 400, F.S. by placing a 'yes' or 'no' in the box provided.

1b. Indicate if this pain-management clinic has ever been licensed with the Agency for Health Care Administration (AHCA) prior to the submission of this application by placing a 'yes' or 'no' in the box provided.

1c. If you selected yes for question 1b, indicate the AHCA license number.

1d. Indicate if the pain-management clinic is exempt from licensure with AHCA by placing a 'yes' or 'no' in the space provided.

1e. Indicate if this pain-management clinic has ever been registered with the Department prior to the submission of this application by placing a 'yes' or 'no' in the space provided.

1f. If you answered yes to question 1e, provide the registration number.

2. Provide the pain-management clinic's corporate or legal name.

3. Provide the 'Doing Business As' name, if applicable.

4. Provide the pain-management clinic's Federal tax identification number (FEIN #).

5. Provide the pain-management clinic's physical address.

6. Provide the pain-management clinic's mailing address.

7. Provide the pain-management clinic's telephone number.

8. Provide the pain-management clinic's facsimile number.

9. Provide the pain-management clinic's email address, if applicable.

10. Provide the pain-management clinic's business operating hours. Also provide the hours the designated physician is present in the pain-management clinics.

IMPORTANT NOTICES:
Section 456.0635, F.S., provides that health care boards or the Department shall refuse to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

- Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, Chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
- Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
- Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

Sections 458.3265 and 459.0137, F.S., provide that the Department shall deny registration to:
• Any pain-management clinic that is not fully owned by a physician licensed under Chapter 458 or Chapter 459, F.S. or a group of physicians, each of which is licensed under Chapter 458 or 459, F.S., or that is not a health care clinic licensed under Part X of Chapter 400, F.S.
• Any pain-management clinic owned by or with any contractual or employment relationship with a physician:

- Whose DEA number has ever been revoked.
- Whose application for a license to prescribe, dispense, or administer a controlled substance has been denied by any jurisdiction.
- Who has been convicted of or pleaded guilty or nolo contendere to, regardless of adjudication, an offense that constitutes a felony for receipt of illicit and diverted drugs, including a controlled substance listed in Schedule I, Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03, in this state, or any other state, or the United States.

11. Provide the names and addresses of any and all pain-management clinic owner(s), principal(s), officer(s), agent(s), managing employee(s), affiliated person(s), and practicing physician(s) – use additional sheets of paper if necessary. If an owner(s), principal(s), officer(s), agent(s), managing employee(s) or affiliated person(s) are licensed health care practitioners, please indicate the license number in the space provided. For the purpose of this question, 'license' refers to a health care license issued by the Department.

12 – 17. DEA/Medicare/Medicaid/Convictions - Check 'yes' or 'no' to the questions listed. If 'yes', explain on a separate sheet of paper providing accurate details. Provide the supporting documentation directly to the Department.

SECTION II: DESIGNATED PHYSICIAN INFORMATION

1. Provide the physician's full name.

2. Provide the physician's Florida MD or DO license number.

3. Provide the physician's email address, if applicable.

4. Provide the physician's telephone number.

5. Provide the physician's mailing address (if different than the address for the pain-management clinic). Note – s. 458.3265 and s. 459.0137, F.S., require the physician to practice at the pain-management clinic location for which the physician has assumed responsibility.

6. Provide the name, address and pain-management clinic registration number for each pain-management clinic being overseen by this designated physician.

SECTION III: ACCREDITATION OR INSPECTION

Each pain-management clinic must be either accredited with a national accrediting organization approved by the Board of Medicine or Osteopathic Medicine or be inspected by a Department inspector. Indicate the appropriate accreditation or inspection.

If you are accredited with an approved nationally recognized accrediting agency, submit a copy of your accreditation certificate.

SECTION IV: DESIGNATED PHYSICIAN STATEMENT

After reading this statement, the designated physician must sign and date the application.

Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, F.S.

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the **Healthiest State** in the Nation

APPLICATION FOR AND CHANGES TO PAIN MANAGEMENT CLINIC REGISTRATION

☐ Registration of pain-management clinic: Initial **($150 Fee Required)**
☐ Registration of pain-management clinic: Change of ownership **($150 Fee required)** – effective date: _____
☐ Registration of pain-management clinic: Change of location **($150 Fee required)** – effective date: _____
☐ Change in pain-management clinic name only **($25 Fee)** – effective date _____
☐ New designated physician **(No fee)** – effective date: _____
☐ Change from accreditation by national and board approved organizations to inspection **(No fee)**
☐ Change from inspection to accreditation by national and board approved organizations **(No fee)**
☐ Request to withdraw or close registration **(No fee)** – effective date: _____

Registration #: _____ (for changes to existing registrations only – the registration number can be found on your registration card)

SECTION I: OFFICE INFORMATION

1a. Is the pain-management clinic wholly owned by a physician licensed under Chapter 458 or Chapter 459, F.S. or a group of physicians, each of which is licensed under Chapter 458 or 459, F.S.; or is a health care clinic licensed under Part X of Chapter 400, F.S. Yes ☐ No ☐

1b. Has this pain-management clinic ever been licensed with the Agency for Health Care Administration (AHCA) under Chapter 400, Florida Statutes? Yes ☐ No ☐

1c. If yes, please provide the license number: _____

1d. Is this pain-management clinic exempt from licensure with AHCA? Yes ☐ No ☐

1e. Has this pain-management clinic ever been registered with the Department of Health? Yes ☐ No ☐

1f. If yes, please provide the registration/license number: _____

2. Corporate or Legal Name of Pain-management Clinic: _____

3. Doing Business As Name: _____

4. Federal Tax Identification Number (FEI#): _____

5. Pain-management Clinic Address: _____
(Street) (Suite #)
_____
(City) (State) (Zip Code)

6. Mailing Address: _____
(Street) (Suite #)
_____
(City) (State) (Zip Code)

7. Pain Management Clinic Telephone Number: ( ) _____

8. Pain Management Clinic Fax Number: ( ) _____

9. Pain Management Clinic Email Address, if available: _____

10. Business Operating Hours:

	Business Operating Hours:	Hours Designated Physician Present in Clinic:
Monday	____ : ____ am/pm to ____ : ____ am/pm	____ : ____ am/pm to ____ : ____ am/pm
Tuesday	____ : ____ am/pm to ____ : ____ am/pm	____ : ____ am/pm to ____ : ____ am/pm
Wednesday	____ : ____ am/pm to ____ : ____ am/pm	____ : ____ am/pm to ____ : ____ am/pm
Thursday	____ : ____ am/pm to ____ : ____ am/pm	____ : ____ am/pm to ____ : ____ am/pm
Friday	____ : ____ am/pm to ____ : ____ am/pm	____ : ____ am/pm to ____ : ____ am/pm
Saturday	____ : ____ am/pm to ____ : ____ am/pm	____ : ____ am/pm to ____ : ____ am/pm
Sunday	____ : ____ am/pm to ____ : ____ am/pm	____ : ____ am/pm to ____ : ____ am/pm

11. Names and addresses of any and all pain-management clinic owner(s), principal(s), officer(s), agent(s), managing employee(s) and affiliated person(s) – **use additional sheets of paper if necessary**. For the purpose of this question, 'license' refers to a health care license issued by the Department of Health.

Owner(s):

Name _____
License Number _____
Address _____
Address _____
Telephone Number _____

Principal(s):

Name _____
License Number _____
Address _____
Address _____
Telephone Number _____

Officer(s):

Name _____
License Number _____
Address _____
Address _____
Telephone Number _____

Agent(s):

Name _____
License Number _____
Address _____
Address _____
Telephone Number _____

Managing Employee(s)

Name _____
License Number _____
Address _____
Address _____
Telephone Number _____

Practicing Physician(s)

Name _____
License Number _____

The following questions are being asked pursuant to Section 456.0635(2), F.S. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details (including the name of the involved party) and submit copies of supporting documentation.

12a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss.1395-1396? (If no, do not answer 12b.) Yes ☐ No ☐

12b Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction? Yes ☐ No ☐

13a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 13b.) Yes ☐ No ☐

13b. If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated for cause, has the applicant been reinstated and in good standing with the Florida Medicaid Program for the most recent five years? Yes ☐ No ☐

14a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 14b and 14c.) Yes ☐ No ☐

14b. Has the applicant been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? Yes ☐ No ☐

14c. Did the termination occur at least 20 years prior to the date of this application? Yes ☐ No ☐

The following questions are being asked pursuant to Sections 458.3265(1) and 459.0137(1), F.S. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details (including the name of the involved party) and submit copies of supporting documentation.

15. Is the applicant owned by or with any contractual or employment relationship with a physician whose DEA number has ever been revoked? Yes ☐ No ☐

16. Is the applicant owned by or with any contractual or employment relationship with a physician whose application for a license to prescribe, dispense, or administer a controlled substance has been denied by any jurisdiction? Yes ☐ No ☐

17. Is the applicant owned by or with any contractual or employment relationship with a physician who has been convicted of or pleaded guilty or nolo contendere to, regardless of adjudication, an offense that constitutes a felony for receipt of illicit and diverted drugs, including a controlled substance listed in Schedule I, Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03, in this state, any other state, or in the United States? Yes ☐ No ☐

SECTION II: DESIGNATED PHYSICIAN INFORMATION

18. Physician Name: _____

19. Physician's Florida License Number: _____

20. Physician's Email address, if available: _____

21. Physician's Telephone Number: _____

22. Mailing Address: _____

(Street) (Suite #)

_____

(City) (State) (Zip Code)

23. List all other pain-management clinics, as defined by statute, currently supervised by this designated physician – **use additional sheets of paper if necessary.**

Name of Pain-Management Clinic	Address (street, city, zip)	Pain-Management Clinic registration number

SECTION III: ACCREDITATION OR INSPECTION

All pain-management clinics required to be registered pursuant to ss. 458.3265(3) or 459.0137(3), F.S., are to be inspected annually by the Department of Health unless the clinic is accredited by a national accrediting agency recognized by the Board of Medicine or the Board of Osteopathic Medicine. Please check the appropriate inspection or accrediting agency:

☐ Inspection by the Department of Health

☐ _____, a Board approved accrediting organization

If you are accredited with a nationally recognized accrediting agency, submit a copy of your accreditation certificate.

SECTION IV: DESIGNATED PHYSICIAN STATEMENT

I hereby state that I and the clinic meet all requirements of s. 458.3265 or s. 459.0137, F.S. I agree to notify the Department of Health in writing within 10 days of any changes to the registration information. All information provided herein is true and correct.

Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, F.S.

Type name of designated physician: _____

Signature of designated physician: _____

Date: _____

Mailing Instructions

The original application with the applicant's original signature must be mailed to the Department of Health (faxed copies are not acceptable).

Mail application and registration fee to:

Department of Health
PO Box 6330
Tallahassee, FL 32314

Note: Post offices do not accept overnight or express packages. For faster delivery, Priority Mail (2-3 days) is accepted by post office boxes.

Submit any additional documentation not included with the original application to:

Department of Health
Pain-Management Clinic Registration Program
4052 Bald Cypress Way, Bin C03
Tallahassee, FL 32399-3253